

THE DIVISION OF HEALTH OF MISSOURI STANDARD CERTIFICATE OF DEATH

State File No. **36197**
Registrar's No. **9583**

FILED NOV 12 1952

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 9583	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (In this place) 1933		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		2219	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital				d. STREET ADDRESS (If rural, give location) 21 3410 rear Washington Ave.			
3. NAME OF DECEASED (Type or Print) Alice		a. (First) Jones		c. (Last) Boyd		4. DATE OF DEATH (Month) (Day) (Year) Oct. 15 1952	
5. SEX Female	6. COLOR OR RACE Colord	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED		8. DATE OF BIRTH March 7-1900		9. AGE (In years last birthday) 52 If under 1 year: Months _____ Days _____ If under 24 hours: Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) Memphis, Tenn.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Joseph Taylor		13b. MOTHER'S MAIDEN NAME Eugene Collins		14. NAME OF HUSBAND OR WIFE Isaiah Jones.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. NOT AN		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Isaiah Jones. 3410 Rear Washington			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cirrhosis of Liver ANTECEDENT CAUSES DUE TO (b) Undetermined DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None				INTERVAL BETWEEN ONSET AND DEATH Undet.	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (a.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 5810			
22. I hereby certify that I attended the deceased from 10-6 , 1952, to 10-15 , 1952, that I last saw the deceased alive on 10-15 , 1952, and that death occurred at 6:10 PM m., from the causes and on the date stated above.							
23a. SIGNATURE Wm. B. Jennings (Degree or title) M. D.				23b. ADDRESS 2601 N Whittier St		23c. DATE SIGNED 10-16-52	
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE OCT 20-1952		24c. NAME OF CEMETERY OR CREMATORY Graceland		24d. LOCATION (City, town, or county) (State) St. Louis, Mo. - Missouri	
DATE REC'D BY LOCAL REG. OCT 17 1952		REGISTRAR'S SIGNATURE J. Carl Smith		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS NO. 3849 Windsor			

WRITE PLAINLY—USING UNFADEING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed

F. A. Green

Licensed Embalmer No.

2963

P. O. Address

4214 Delmar

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.